RTMENT OF HEALTH AND HUMAN SERVICES
H CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

OR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-0001

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

EDERAL STATUTE/REGULATION CITATION:
tion 1902(a)(13) & 1902(a)(30) of the Act
42 CFR 447.250 through 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $20.07m
b. FFY 2002 $12.35m

AGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D(4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

UBJECT OF AMENDMENT:
Nursing Facility Services Payment Methodology

OVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not requiried under 42 CFR 430.12(b)(2)(i)

GNATURE OF STATE AGENCY OFFICIAL:

TYPED NAME:
Wendy E. Warring

TLE:
Commissioner

ATE SUBMITTED:
March 30, 2001

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 30, 2001

18. DATE APPROVED:
May 15, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
D. M. Maloney 5/15/01

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO

REMARKS:

OFFICIAL

HCFA 179 (07 92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MASSACHUSETTS MEDICAL ASSISTANCE PROGRAM

Methods Used to Determine Rates of Payment for Nursing Facilities

I. GENERAL DESCRIPTION OF PAYMENT METHODOLOGY

A. Overview: Nursing facility payments for services rendered to publicly-assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: Standard **Payments to Nursing Facilities**. The following sections in this attachment describe the methods and standards used to establish payment rates for nursing facilities effective ***January 1, 2001***.

B. Chief Components: The payment method, described below, continues the shift away from historical facility specific cost-based reimbursement to standard payments for nursing facility services. The payment method contains a blend of facility-specific costs and standard payment rates for Nursing and Other Operating Costs, as well as payment rates for Capital. Nursing and Other Operating rates were calculated using FY 1998 updated by a CAF of ***7.59%***. The allowable basis for capital was updated using FY 1998 data. For Rate Year ***2001*** , there continue to be several transition adjustments to ease the transition to standard payments.

II. COST REPORTING REQUIREMENTS AND COST FINDING

A. Required Reports: Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. There are **four (4)** reports required: a) Nursing Facility Cost Report; b) Realty Company Cost Report; *c)* Management Company Cost Report, ***and d) Quarterly Nursing Expense Reports***. All cost reporting must meet the requirements set forth in Appendix A (114.2 CMR 6.07 (2)). There are special cost reporting requirements for Hospital Based Nursing Facilities and facilities which operate other programs such as Adult Day Health, Assisted Living or Outpatient Services. These requirements are outlined in Appendix A (114.2 CMR 6.07 (2)(f)) .

B. Filing Dates: Reports: Except as provided below, Providers must file the required Cost Reports for the calendar year by 5:00 PM of April first of the following calendar year. If April 1 falls on a weekend or holiday, the Reports are due by 5:00 PM of the following business day.

1. Change of Ownership. Where there has been a change of ownership, the transferor shall file the Report(s) within sixty (60) days after the transfer of ownership. Where the transferor fails to submit the Report(s), the Division of Health Care Finance and Policy may request the Division of Medial Assistance to withhold payment to the transferee until such reports are appropriately filed.

2. New Facilities and Facilities with Major Additions. For the first two calendar years of operation, New Facilities and Facilities with Major Additions shall file year-end Cost Reports within sixty (60) days after the close of the calendar year.

3. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility that is licensed for both hospital and long-term-term care services, where the long-term-term care beds were converted from

licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Report(s) on a fiscal year basis that is consistent with the filing of such facilities' hospital cost reports. The Report(s) is due no later than ninety (90) days after the close of the facility's fiscal year.

4. Termination of Provider Contract. Whenever a provider contract between the provider and the Division of Medical Assistance is terminated, the provider shall file Reports covering the current reporting period or portion thereof covered by the contract and any other Reports required by the Division of Health Care Finance and Policy, within sixty (60) days of such termination. When the provider fails to file the required Reports in a timely fashion, the Division of Health Care Finance and Policy shall notify the provider of this failure by written notice sent registered mail, return receipt requested

5. Appointment of Patient Protector Receiver. If a receiver is appointed pursuant to court order under M.G.L. c. 111, s. 72N, the provider must file Reports for the current reporting period or portion thereof within sixty (60) days of the receiver's appointment.

C. Filing Extensions: The Division of Health Care Finance and Policy may grant an extension, up to forty-five (45) calendar days, for submission of the Report(s). Extension must: (a) be submitted in writing to *DHCFP* by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. Incomplete Submission: *DHCFP* shall notify the provider within one hundred twenty (120) days of receipt of the Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with *DHCFP* within twenty-five (25) days of the date of notification or by April 1 of the year the Report is filed, whichever is later. The Reports and all accompanying schedules is deemed to be filed with the *DHCFP* as of the date the Division of Health Care Finance and Policy receives complete submission.

If the Division of Health Care Finance and Policy fails to notify the provider within the 120-day period, the submission is considered complete and the Report(s) and all accompanying schedules is deemed to be filed with the Division of Health Care Finance and Policy as of the date of receipt.

E. Audits: The Divisions of Health Care Finance and Policy and Medical Assistance may conduct desk or field audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any related party as requested, even if the Division of Health Care Finance and Policy has accepted such Provider Cost Reports.

F. Penalties for Failure to File Timely: A provider's rate for current services will be reduced in accordance with the formula contained in 114.2 CMR 6.07(8) (Appendix A) if the required Cost Reports are not filed in a timely manner. On receipt of such cost reports, the Provider's rate will be restored effective on the date of report filing.

G. General Cost Principles: In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

1. The cost is ordinary, necessary and directly related to the care of publicly aided patients;
2. The cost is for goods or services actually provided in the nursing facility

3. The cost must be reasonable; and,
4. The provider must actually pay the cost. Costs which are not considered related to the care of Medicaid patients include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates.

A provider may not report any of the costs that are listed in 114.2 CMR 6.07 (2) (e) (Appendix A) as related to Medicaid patient care.

III. METHODS AND STANDARDS USED TO DETERMINE PAYMENT RATES

A. Prospective Per Diem Rates: **The** prospective per diem payment rates for nursing facilities are derived from several components: Nursing, Other Operating, Capital, RY ***2001*** Transition Payments, and a Total Payment Adjustment. Each of these components is described in detail in the following sections.

B. Nursing Cost. The Nursing cost component consists of a blend of facility-specific costs and standard payments, as follows:

1. Allowable Nursing Costs: Facility-specific allowable nursing per diem costs are computed in accordance with 114.2 CMR 6.03(2) (a) (1) (Appendix A, pp. 5- 6), using reported 1998 nursing costs and 1998 management minutes and subject to a cost adjustment factor of ***7.59% (1998-2001)*** . The cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by DRI.

2. Standard Payments for Nursing: The base year used to develop the Nursing Standard Payments is 1998. Nursing costs reported in 1998 in the following categories are included in the calculation: Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Director of Nurses and Nursing Workers' Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense. The Nursing Standard Payments are derived from the product of the industry 1998 median nursing costs times the 1998 industry median management minutes for each of six (6) payment groups listed in 114.2 CMR 6.03(1) (Appendix A, p. 5). The base year amounts for each group are updated to rate year ***2001*** by a cost adjustment factor of ***7.59%*** This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by DRI.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 - 30	***$10.07***
JK	30.1 - 110	***$26.86***
LM	110.1 - 170	***$47.61***
NP	170.1 - 225	***$66.48***
RS	225.1 - 270	***$83.47***
T	270.1 & above	***$101.31***

3. Calculation of Nursing Rate Component: For five of the Payment Groups JK to T, the Nursing rate component ***is the sum of 20%*** of the Allowable Nursing Per Diem Costs ***and 80% of the Nursing Standard Payments.***For Payment Group H, the Nursing Standard Payment is used.

C. Other Operating Cost. The Other Operating Cost component consists of a blend of facility-

specific costs and standard **payments as follows:**

1. Allowable Other Operating Costs: Allowable other operating per diem costs for each nursing facility are computed in accordance with 114.2 CMR 6.04(2) (a) (Appendix A, pp. 6-7), using reported 1998 operating costs, subject to a ceiling on administrative and general costs of $11.48 per diem and an overall ceiling of $54.14 (industry median plus 6%), and increased by the cost adjustment factor of ***7.59% (1998-2001)*** The cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as nation and regional indices supplied by DRI.

2. Standard Payment for Other Operating: The base year used to develop the Other Operating Standard Payment ***of $54.96*** is 1998. Other operating costs reported in 1998 in the following categories are included in the calculation: variable, administrative & general, and motor vehicle costs. The Other Operating Standard Payment is set equal to the 1998 industry median of these cost amounts, except for Administrative & General costs which are subject to a ceiling of $11.48 before combining with other cost components. The 1998 amount is updated to rate year ***2001*** by a cost adjustment factor ***of 7.59%*** . This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as nation and regional indices supplied by DRI.

3. Calculation of Other Operating Rate Component: For five of the Payment Groups JK to T, the other operating rate component ***is the sum of 20% of the Allowable Other Operating Per Diem Costs and 80% of the Other Operating Standard Payment.*** For Payment Group H, the Other Operating Standard Payment is used.

D. Capital: The Capital component is computed in accordance with 114.2 CMR 6.05 (2) (Appendix A), using the allowable depreciation, financing contribution, and other fixed costs based on the allowable basis of fixed assets as of December 31, 1998.

1. ***Determination of RY 2001 Capital Payments: For beds licensed prior to 2001, the capital payment will equal the facility's capital payment in its presently certified rates (in effect on December 30, 2000), calculated as described in 114.2 CMR 6.05(2)(c) (Appendix A):***

2. ***Capital Payment Adjustment. Qualifiying providers are eligible for a capital payment adjustment as calculated in 114.2 CMR 6.05(2)(d)2 of Appendix A.***

3. Capital Payment Exceptions: For the following facilities that meet the criteria in 114.2 CMR 6.05 (1) (Appendix A), the Capital component ***per diem for rate year 2001 is $18.24 :***

a) New Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
b) Replacement facilities that open pursuant to a Determination of Need approved after March 7, 1996;
c) New Facilities in Urban Underbedded areas that are exempt from the Determination of Need process;
d) New beds that are licensed pursuant to a Determination of Need approved after March 7, 1996;
e) New beds in twelve-bed expansion projects not associated with an approved Determination of Need project;
f) Hospital-Based Nursing Facilities; and
g) Private Nursing Facilities that sign their first Provider Agreement in *2001*

3. Notification of Substantial Capital Expenditures. Any nursing facility which opens in ***2001*** or adds new beds or adds substantial renovations in ***2001*** or re-opens beds is required to notify the Division of Health Care Finance and Policy in accordance with 114.2 CMR 6.05(3) (a) (Appendix A). At that time, the Capital component may be recomputed in accordance with 114.2 CMR 6.05(3) (b) (Appendix A).

E. *Add-on for Certified Nursing Assistants: An add-on is computed in accordance with*

114.2 CMR 6.06 (1) (c) (1) (Appendix A) for the purpose of funding increases in the ***salaries and associated payroll taxes*** of Certified Nursing Assistants. The Division of Health Care Finance and Policy will conduct a retrospective review of the add-on to verify whether the add-on is expended as intended. If a nursing facility does not expend the add-on for Certified Nursing Assistants as intended, an overpayment amount will be determined to reflect the amount that is not properly expended. ***See, February 2, 2001 proposed amendment 114.2 CMR 6.06(1)(d) (Appendix B)***

F. Total Payment Adjustment: A total payment adjustment is applied to the payment rates. The total payment adjustment is computed in accordance with 114,2 CMR 6.06(1)(b) (Appendix A) to buffer the impact of changes in rate methodology from prior years. According to the formula, all rate changes from the prior year are moderated within the range of *2-6%* .

G. Retroactive Adjustments: The Division of Health Care Finance and Policy will retroactively adjust rates according to 114.2 CMR 6.06(2) (Appendix A) in the following situations: Facilities which did not file a 1998 Cost Report, Amended Rates for Prior Years, *Mechanical Errors, and Errors in the Cost Reports.*

IV. Special Conditions

A. Rate for Innovative and Special Programs: The Division of Medical Assistance may contract for special and/or innovative programs to meet special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as a program for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e. Management Minute Category T).

B. A provider who seeks to participate in an innovative and special program must contract with the Division of Medical Assistance to provide special care and services to distinct categories of patients designated by the Division of Medical Assistance. This is usually done through a Request for Responses by the Division of Medical Assistance for special or innovative programs to address special needs of certain patients that are not ordinarily met by existing services in nursing facilities. Payment under the innovative and special programs may be calculated based on the added reasonable and necessary costs and expenses that must be incurred (as determined by the Division of Medical Assistance) by a provider in connection with that program. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the Medical Assistance Program, and that such items or services are reasonable and appropriate in the efficient delivery of necessary health care. The rate for an innovative and special program may be established as as add-on to a rate established by DHCFP under 114.2 CMR 6.0 or as as a stand-alone rate established by contract under M.G.L. c. 118E, s12. In either instance, the rate must be consistent with the payment methodology established for long-term care facilities. In either instance, the rate must be consistent with the payment methodology established for long-term care

facilities. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

C. A facility that has recently converted from a facility providing non-acute hospital services to a facility providing nursing facility services may be reimbursed as a special program. In order to be considered as a special program, such a facility must agree to provide, or arrange and pay for, all Medicaid covered services, except hospital services, to all Medicaid recipients that are residents of the facility. The reimbursement to such facilities is a per diem rate which is the facility's regular case mix rates with an add-on which is based on the reasonable costs of providing the goods and services beyond those required to be provided by nursing facilities.

D. A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board; and,

2. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to quality for MM category 10; and,

3. the facility must be a geriatric nursing facility.

E. Pediatric Nursing Facilities: Payments will be determined using 1998 reported costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be subject to a cap of $ 11.48.

F. Pilot Program for Ancillary Costs: Nursing facilities that applied to the Division of Medical Assistance to participate in an alternative Ancillary Pilot Program for payment of Ancillary services may receive incentive payments. Participation is voluntary, subject to approval by the Division of Medical Assistance. **Appendix E**. contains the payment methodology for incentive payments that may be made to the providers who participated in the voluntary Ancillary Pilot Project commencing in December 1, 1998.

G. Beds Out of Service: Facilities with licensed beds that were out of service prior to 2001 that re-open in 2001 will receive the lower of the Standard Payment rates or the most recent prior billing rates inflated to 2001 for Nursing and Other Operating Costs.

H. Legislative Mandate for Rate Relief: A nursing home (i) with rate of public utilization, consisting of Medicare, Medicaid and Commission for the Blind patients, of ninety percent or more, (ii) located in the service area of a federally designated sole community hospital, and (iii) with more than 10% of its variable costs and nursing costs disallowed by the Division of Health Care Finance and Policy pursuant to 114.2 CMR 5.00 or any successor regulation, shall have all of its variable costs and nursing costs recognized by the Division of Health Care Finance and Policy and its Medicaid rate adjusted accordingly. The Division of Health Care Finance and

Policy shall adjust the prospective rates for any such nursing home that meet the aforementioned criteria for the rates that were effective January 1, 1994 and for each succeeding rate year that such nursing homes comply with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by the Division of Health Care Finance and Policy for any rate for a nursing home is limited to an amount that will not increase costs to the Medical Assistance program in an amount greater that three hundred thousand dollars. Not withstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to February 1. 1998.

Any nursing facility that meets either the standards set forth in **(a) or (b)** below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the Division of Medical Assistance calculates the facility's payment rates. This provision shall only apply to services rendered on or after February 1, 1998.

(a)

- the owner purchased the nursing home on or after January 1, 1987;
- the owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;
- the owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts which is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital which is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health;
- the owner's patient population is, on average, not less than eighty-five percent (85%) Medicaid recipients;
- the Hospital has, on average, not less than eighty percent (80%) occupancy of medical or surgical beds;
- when the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization which is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder or administrator of the owner by common ownership or control or in a manner specified in section 267(b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing, or refinancing: or

(b)

- the owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the acute care hospital conversion board pursuant to M.G.L. c.6A, s.101;
- the acute care hospital conversion board approved the owner's acquisition costs of the facility; and,

- on average, no less than eight-five percent (85%) of the nursing facility's patient population are Medicaid recipients.

I. Notwithstanding anything to the contrary contained in this State Plan, any nursing home that is owned by the Martha's Vineyard Hospital Foundation during the time that said Foundation also administers a federally designated sole community provider hospital shall have allowed all of its extra variable and fixed costs that reasonably result from such nursing home being located in a geographically isolated area.

J. ***Receivership Under M.G.L. c.111 s.72N et seq. (see Appendix C); Provider rates of a nursing facility in receivership may be adjusted by DHCFP to reflect the reasonable and necessary costsassociated with the court-approved closure of the facility.***

K. Review and Approval of Rates and Rate Methodology By The Division of Medical Assistance: Pursuant to M.G.L. c 118E, s.13 (see Appendix D) the Division of Medical Assistance shall review and approve or disapprove, any change in rates or in rate methodology proposed by the Division of Health Care Finance and Policy. The Division of Medical Assistance shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the Division of Health Care Finance and Policy; provided that, the Division of Medical Assistance shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the Massachusetts House and Senate Committees on Ways and Means. The Division of Medical Assistance shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the Division of Health Care Finance and Policy together with such recommendations for changes. Such disapproval and recommendations for changes, if any, is submitted to the Division of Health Care Finance and Policy after the Division of Medical Assistance is notified that the Division of Health Care Finance and Policy intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the Division of Health Care Finance and Policy regarding such rate change; provided that no rates shall take effect without the approval of the Division of Medical Assistance. The Division of Health Care Finance and Policy and the Division of Medical Assistance shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means.

L. The Division of Health Care Finance and Policy shall supply the Division of Medical Assistance with all statistical information necessary to carry out the Division's review responsibilities under this Section. Not withstanding the foregoing, said Division of Medical Assistance shall not review, approve, or disapprove any such rate set pursuant to Chapter twenty-three of the Massachusetts Acts of Nineteen Hundred and eighty-eight.

M. If projected payments from rates necessary to conform to applicable requirements of title XIX are estimated by the Division of Medical Assistance to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Division of Medical Assistance and the Division of Health Care Finance and Policy shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division of Medical Assistance under Title XIX of the Federal Social Security Act.

N. Appeals: A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division of Health Care Finance and Policy files the rate with the State Secretary. The Division of Health Care Finance and Policy may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

Appendix E.
Division Medical Assistance
Bulletin 115
Ancillary Pilot Project

1. The Provider has received prior written approval from the Executive Office of Elder Affairs to establish and maintain a program; or
2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

(8) Receiverships. The Division may adjust the rate of a receiver appointed under M.G.L. c. 111, s. 72N solely to reflect the reasonable costs, as determined by the Division and Division of Medical Assistance, associated with the court-approved closure of the facility.

6.07 Reporting Requirements

(1)Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses.

(b) Realty Company Cost Report.. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.

(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(d) Quarterly Nursing Expense Reports. A Provider must file a Quarterly Nursing Expense Report within 45 days of the end of each quarter.

(2) General Cost Reporting Requirements

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger which clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions which the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:

a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;

b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, which are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and

c. Expenses related to policy-making, planning and decision-making activities necessary for the general and Long-Term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.

d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses which Generate Income. Providers must identify the expense accounts which generate income.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets which are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment , accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and